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CHAPTER THIRTEEN

SUPPLIES, APPLIANCES, AND DURABLE EQUIPMENT

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Chapter 13. Supplies, Appliances, and Durable Equipment

Rule No. 560-X-13-.01. Supplies, Appliances, and Durable Medical Equipment - General.

(1) Effective July 1, 1978, supplies, appliances, and durable medical equipment are available as Medicaid program benefits to Medicaid eligibles of any age living at home.

(2) The covered medical supplies, appliances, and durable medical equipment are for medical therapeutic purposes, must be ordered by the attending physician in connection with his plan of treatment, and the items will minimize the necessity for hospitalization, nursing home, or other institutional care.

(3) A recipient does not have to be a Home Health Care patient in order to avail herself/himself of this program.

(4) The provider is responsible for educating the recipient in the use of the equipment. The provider is also responsible for delivery and set up of the equipment.

(5) Standard supplies, appliances, and durable medical equipment covered by Medicaid are listed in Chapter 14, of The Alabama Medicaid Provider Manual. Medical equipment, supplies, and appliances not listed as covered services in Chapter 14 of the Alabama Medicaid Provider Manual may be requested for coverage by submitting the request to the Long Term Care Division for review and consideration. It will be the provider's responsibility to supply Medicaid with the necessary medical documentation which justifies the need of the requested items.

(6) Requests for items that are covered by Medicaid which are outside the normal benefit limits, due to damage beyond repair or other extenuating circumstances must be submitted to the Long Term Care Division for review and consideration. It will be the provider's responsibility to supply Medicaid with the necessary documentation which justifies the need for the requested items.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: State Plan; 42 CFR Section 440.70; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended November 11, 1985, March 10, 1997, and July 9, 1997. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.02. Participating Agencies and Suppliers.

(1) Participating agencies are those Home Health Agencies contracted with Alabama Medicaid Agency for this program.

(2) Participating suppliers are those pharmacies and medical equipment suppliers contracted with Alabama Medicaid Agency for this program.

(3) The provider's business must be physically located within the state of Alabama or within a thirty (30)-mile radius of the state of Alabama. Suppliers located more than thirty (30) miles from the border of Alabama may be enrolled only as follows:

(a) For specialty equipment and supplies such as augmentative communication devices and vest airway clearance systems which are not readily available instate;

(b) For supplies and equipment needed as the result of a transplant or unique treatment approved out of state as the result of an EPSDT referral. Suppliers will be enrolled by the Medicaid fiscal agent on a temporary basis for these situations.

(4) There must be at least one person present to conduct business at the physical location. Answering machines and/or answering services are not acceptable as personal coverage during normal business hours (8:00 a.m. – 5:00 p.m.).

(5) Satellite businesses affiliated with a provider are not covered under the provider agreement; therefore, no reimbursement will be made to a provider doing business at a satellite location. However, the satellite could enroll with a separate provider number.

(6) The provider shall have no felony convictions and no record of noncompliance with Medicaid or Medicare regulations.

(7) The provider must submit a copy of a current business license to EDS.

(8) Providers must notify EDS in writing of any changes to the information contained in its application at least 30 business days prior to making such changes. These changes may include, but are not limited to, changes in ownership or control, federal tax identification number, or business address changes.

Author: Hattie Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 434.6; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended: Filed December 17, 2001; effective March 15, 2002. **Amended:** Filed November 19, 2002. Effective February 14, 2003. **Amended:** Filed September 20, 2006; effective December 13, 2006. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-13-.03. Supplies and Appliances.

(1) A written order or a signed prescription by the attending physician to a participating supplier determines medical necessity for needed covered items of supplies and appliances.

(2) No prior authorization by Alabama Medicaid Agency is required.

(3) Procedures for requesting and dispensing medical supplies and appliances for Medicaid recipients living at home are as follows:

(a) It is the responsibility of the recipient or authorized representative to obtain the prescription from the attending physician and take to a participating supplier.

(b) Upon receipt of the prescription, the supplier will:

1. verify Medicaid eligibility;
2. furnish the covered item(s) as prescribed;
3. retain the prescription on file; and
4. submit the proper claim form to Medicaid's fiscal agent.

(4) Prescriptions are retained in patient's record or record file.

Authority: State Plan; 42 CFR Section 440.70; and Title XIX, Social Security Act. Rule effective October 1, 1982. Amended November 11, 1985. Effective date of this amendment January 13, 1993.

Rule No. 560-X-13-.04. Durable Medical Equipment.

(1) Prior authorization by Alabama Medicaid Agency is required for certain items of covered durable medical equipment.

(2) Medicaid covers the purchase of durable medical equipment items for long term use; long term use is defined as the use of durable medical equipment which exceeds six months. Medicaid covers durable medical equipment items as a rental for EPSDT related-services for use less than six months. Selected medical equipment, which is prescribed as medically necessary, will be rented on a short-term basis for Medicaid eligible adults over age 21.

(3) Equipment may be purchased or rented for any Medicaid recipient meeting the established criteria.

(4) Durable Medical Equipment (DME) is equipment which:

(a) can stand repeated use;
(b) is used to serve a purpose for medical reasons; and
(c) is appropriate and suitable for use in the home.

(5) Durable Medical Equipment is necessary when it is expected to make a significant contribution to the treatment of the patient's injury or illness or to the improvement of his physical condition.

(6) The item is not disproportionate to the therapeutic benefits or more costly than a reasonable alternative. The item would not serve the same purpose as equipment already available to the recipient.

Author: Hattie Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 440.70; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended November 11, 1985; March 10, 1997; and July 9, 1997. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-13-.05. Method of Requesting Durable Medical Equipment.

(1) A Medicaid recipient's attending physician is responsible for prescribing any covered durable medical equipment that is medically necessary for use in the patient's home.

(2) The physician must complete a written order or prescription and give to the recipient or sponsor to take to the DME provider of their choice. The physician may also fax the prescription to the provider of the recipient's choice. The provider must submit the appropriate Alabama Prior Review and Authorization Request Form, Form 342 and any other pertinent medical information to the Medicaid Fiscal Agent. The information may be transmitted electronically or by mail. The Fiscal Agent will assign a prior authorization tracking number and transmit the request to Medicaid's Prior Approval Unit for review and approval.

(3) The Medicaid Prior Approval Unit will review the request and assign a status of approved, denied, or returned.

(a) If the request is approved, the provider and recipient will receive an approval letter with a ten-digit PA number. This information should be referenced on the claim for billing.

(b) If the request is denied, written notice will be sent to the provider and the recipient indicating the reason for denial. Information giving them their right to appeal is also included in this notice.

(4) All prior authorization requests for the purchase of durable medical equipment must be received by the Medicaid Fiscal Agent within 30 calendar days after equipment is dispensed.

(5) All prior authorization requests for certification of rental services received beyond the thirty (30) calendar days of beginning services will be authorized for reimbursement effective the date of receipt at the Medicaid Fiscal Agent.

(6) All prior authorization requests for recertification of DME rental services must be submitted to the Medicaid Fiscal Agent within 30 calendar days of recertification date. Completed recertifications received beyond the established time limit will be authorized for reimbursement effective the date of receipt at the Medicaid Fiscal Agent.

(7) All prior authorization requests returned to the DME provider by Medicaid, if resubmitted, must contain the following:

(a) The appropriate Alabama Prior Review and Authorization Request Form,

(b) The EPSDT Referral Form, if applicable

(c) All necessary documentation to justify medical necessity.

(8) Prior authorization requests that are lacking necessary information (EPSDT screening, referrals, required attachment) are placed in pending status. Prior authorization requests that are pended based on the need for additional information will be denied if information necessary to process the request is not received by the Prior Authorization Unit within 21 calendar days of the request.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; 42 C.F.R., Section 440.70; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended August 9, 1984; and March 10, 1997; and July 9, 1997. Amended: File August 21, 2001; effective November 16, 2001.
Amended: Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.06. Participating Supplier.

(1) The supplier furnishes only the approved item(s) indicated on the approval letter from the Alabama Medicaid Prior Approval Unit. This letter is generated and mailed by the Alabama Medicaid Fiscal Agent.

(2) The supplier is also responsible for verifying recipient's eligibility monthly.

(3) Upon furnishing durable medical equipment/supplies, the supplier must obtain a signature on any form he/she desires indicating that the equipment/supplies have been received by the recipient. If the recipient is unable to sign for the equipment/supply items, the supplier should verify the identity of the person signing for the items, e.g., relative, home health worker, neighbor.

(4) All forms and documentation must be retained in the patient record file by the supplier.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; 42 CFR Section 440.70; and Title XIX, Social Security Act.

History: Rule effective October 1, 1982. Amended November 11, 1985; October 12, 1988; November 15, 1989; January 13, 1993; and March 10, 1997. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.07. Noncovered Items and Services.

(1) Items of a deluxe nature.

(2) Replacement of usable equipment.

(3) Items for use in hospitals, nursing homes, or other institutions.

(a) DME items may be provided in nursing homes or other institutions for children through the EPSDT Program.

(4) Items for patient/caring person's comfort and convenience.

Author: Hattie Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachment 3.1-A; 42 CFR Section 441.15; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Effective date of this amendment March 10, 1997. **Amended:** Filed February 20, 2008; effective May 16, 2008.

Rule No. 560-X-13-.08. Medicare-Medicaid Eligibles and/or Qualified Medicare Beneficiaries.

(1) Refer to Rule No. 560-X-1-.14.

Authority: 42 CFR Section 431.625; State Plan, Attachment 3.2-A; and Title XIX, Social Security Act. Rule effective October 1, 1982. Amended January 8, 1985, and October 13, 1987. Emergency rule effective February 1, 1989. Effective date of this amendment May 12, 1989.

Rule No. 560-X-13-.09. Patient Identification.

(1) Refer to Rules 560-X-1-.09. and 560-X-1-.11.

Authority: State Plan; 42 C.F.R. Section 435.10; and Title XIX, Social Security Act. Rule effective October 1, 1982. Effective date of this amendment September 9, 1988.

Rule No. 560-X-13-.10. Reimbursement.

(1) Medicaid will reimburse for only those DME items indicated on the approval letter from the Alabama Medicaid Prior Approval Unit.

(2) Reimbursement will be made for item(s) covered by the Alabama Medicaid Agency for purchase, using limits as established by Medicaid.

(3) Request for reimbursement must be submitted on the appropriate claim form.

(4) The contract supplier agrees to accept as payment in full the amount paid by Medicaid for covered items.

(5) Medicaid recipients may be billed for noncovered items.

(6) Medicaid recipients may be billed for items provided by noncontract suppliers.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan, Attachment 4.19-B, page 5; 42 C.F.R., Section 447.50; Section 447.252; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended July 9, 1984 and June 8, 1985. Amended: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.11. Non-reimbursement.

(1) DME item(s) furnished by a supplier without receipt of an authorization to purchase by the Alabama Medicaid Agency will not be approved for reimbursement.

(2) Item(s) supplied to an individual who is not eligible during the month in which the item(s) are furnished, are not reimbursable.

(3) Medicaid recipients cannot be reimbursed directly by the Alabama Medicaid Agency.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: 42 C.F.R., Section 447.252; and Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended January 8, 1985 and March 10, 1997. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.12. Cost-Sharing.

(1) Medicaid recipients are required to pay and suppliers are required to collect the designated co-pay amount for each prescribed item covered under the Medicaid Supplies, Appliances, and Durable Medical Equipment Program.

(2) The cost-sharing fee does not apply to recipients under eighteen years of age, pregnant women, surgical fees, family planning, and certified emergencies.

(3) A provider may not deny services to any eligible recipient due to the recipient's inability to pay the cost-sharing amount imposed.

Author: Diane M. McCall, Associate Director, LTC Project Development/Policy Unit.
Statutory Authority: 42 C.F.R. Section 447.50; State Plan, Attachment 4.19-B, page 5; and Title XIX, Social Security Act.
History: Rule effective June 8, 1985. Amended: Filed March 20, 2001; effective June 15, 2001.

Rule No: 560-X-13-.13. Reimbursement for EPSDT-referred Wheelchair Systems.

(1) If no Medicare price is available for EPSDT-referred wheelchair systems, the reimbursement rate is established based on a discount from Manufacturers Suggested Retail Price (MSRP) instead of a "cost-plus" basis.

(2) Providers are required to submit MSRPs from three manufacturers for wheelchair systems (excluding seating system and add-on products) appropriate for the individual's medical needs.

(3) Requests submitted with less than three prices from different manufacturers must contain documentation supporting the appropriateness and reasonableness of equipment requested for a follow-up review by Medicaid professional staff. Provider must document nonavailability of required MSRPs to justify not sending in three prices.

(4) The established rate will be based on the MSRP minus the following discounts:

1. Manual Wheelchair Systems - 20% discount from MSRP.
2. Power Wheelchair Systems - 15% discount from MSRP.
3. Ancillary (add-on) products - 20% discount from MSRP.

(5) Suppliers requesting approvals for medical items must provide Medicaid with an expected date of delivery.

(6) For medical items approved based on medical necessity, Medicaid will indicate the time frame allowed for providers to dispense equipment on the approval letter.

(7) When a provider is unable to dispense equipment within the time frame specified on the approval letter, an extension may be requested with written justification as to the specific reason(s) why the equipment cannot be supplied timely. All requests for extensions must be submitted to Medicaid prior to the expiration date indicated on the approval letter.

(8) Medicaid will cancel approvals for medical items that are not dispensed timely when there is no justifiable reason for delay.

(9) The Medicaid screening provider and recipient will be notified when an approved request for equipment is cancelled due to provider noncompliance and the recipient will be referred to other Medicaid providers to obtain medical items.

Author: Patricia Harris, Administrator, LTC Program Management Unit
Statutory Authority: Title XIX, Social Security Act; 42 C.F.R. Section 440.70; State Plan, Attachment 4.19-B; and OBRA '89.
History: Emergency rule effective September 1, 1993. Amended December 14, 1993. Emergency rule effective July 5, 1994. Effective date of this amendment August 12, 1994. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No: 560-X-13.-14 Augmentative Communication Devices

(1) Effective July 1, 1998 coverage is provided for Augmentative Communication Devices (ACD) for eligible individuals who meet criteria set out herein. Prior authorization for the ACD service is required. Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form. The request must include documentation regarding the medical evaluation by the physician and recipient information.

(2) ACDs are defined as portable electronic or non-electronic aids, devices, or systems determined to be necessary to assist a Medicaid-eligible recipient to overcome or ameliorate severe expressive speech-language impairments/limitations due to medical conditions in which speech is not expected to be restored, and which enable the recipient to communicate effectively. These impairments include but are not limited to: apraxia of speech, dysarthria, and cognitive communication disabilities. These devices are reusable equipment items which must be reasonable, a necessary part of the treatment plan consistent with the diagnosis, condition or injury, and not furnished for the convenience of the recipient or his family. ACD components and/or accessories prescribed or intended primarily for vocational, social, or academic development/enhancement and which are not necessary as described above will not be provided.

(3) The scope of services includes the following elements:
   (a) Screening and evaluation,
   (b) ACD, subject to limitations, and
   (c) Training on use of equipment.

(4) Candidates under the age of 21 must meet all of the following criteria:
   (a) EPSDT referral by Medicaid-enrolled EPSDT provider. Referral must

be within one year of application for ACD. The EPSDT provider must obtain a referral from the *Patient 1st* primary care provider where applicable;

(b) Medical condition which impairs ability to communicate as described herein;

(c) Evaluation by required qualified, experienced professionals; and

(d) Physician prescription to be obtained after the evaluation and based on documentation contained in the evaluation.

(5) Candidates over the age of 21 must meet all of the following criteria:

(a) Referral from a primary care physician (*Patient 1st* PCP/PMP where applicable). Referral must be within one year of application for ACD;

(b) Medical condition which impairs ability to communicate as described herein;

(c) Evaluation by required qualified experienced professionals; and

(d) Physician prescription to be obtained after the evaluation and based on documentation provided in the evaluation.

(6) The candidate must be evaluated by qualified interdisciplinary professionals. Interdisciplinary professionals ***must*** include all of the following:

(a) Speech/Language Pathologist: This professional must meet all of the following criteria:

1. Have a master's degree in speech/language pathology from an accredited institution;

2. Have a Certificate of Clinical Competence in Speech/Language Pathology from the American Speech, Language, Hearing Association;

3. Have an Alabama license in speech/language pathology;

4. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs; and

5. Have current continuing education.

(b) Physician: This professional must meet all of the following criteria:

1. Be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which the doctor performs such functions; and

2. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

Interdisciplinary professionals ***should*** include the following:

(c) Physical Therapist: This professional must meet all of the following criteria:

1. Have a bachelor's degree in physical therapy from an accredited institution;

2. Have an Alabama license in physical therapy; and

3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(d) Social Worker: This professional must meet all of the following criteria:

1. Have a bachelor's degree in social work from an accredited institution;

2. Have an Alabama license in social work; and

3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(e) Occupational Therapist: This professional must meet all of the following criteria:

1. Have a bachelor's degree in occupational therapy from an accredited institution;

2. Have an Alabama license in occupational therapy; and

3. Have no financial or other affiliation with a vendor, manufacturer, or manufacturer's representative of ACDs.

(7) ACDs and services are only available through the ALABAMA MEDICAID AGENCY prior authorization process. Requests for authorization must be submitted to Medicaid for review. Documentation must support that the client is mentally, physically, and emotionally capable of operating/using an ACD. The request must include all of the following documentation:

(a) Medical Evaluation by a Physician must meet all of the following criteria:

1. Medical examination by physician to assess the need for an ACD to replace or support the recipient's capacity to communicate;

2. Status of respiration, hearing, vision, head control, trunk stability, arm movement, ambulation, seating/positioning and/or ability to access the device; and

3. Must have been conducted within 90 days of request for ACD.

(b) Recipient Information must include all of the following:

1. Name;

2. Medical assistance/Medicaid number;

3. Date(s) of assessment;

4. Medical diagnoses (primary, secondary, tertiary); and

5. Relevant medical history.

(c) Sensory Status (by physician) must include all of the following:

1. Vision status;

2. Hearing status; and

3. Description of how vision, hearing, tactile, and/or receptive communication impairments affect expressive communication (e.g., sensory integration, visual discrimination).

(d) Postural, Mobility, and Motor Status must include all of the following:

1. Motor status;

2. Optimal positioning;

3. Integration of mobility with ACD; and

4. Recipient's access methods (and options) for ACD.

(e) Developmental Status must include all of the following:

1. Information on the recipient's intellectual/cognitive/developmental status; and

2. Determination of learning style (e.g., behavior, activity level).

(f) Family/Caregiver and Community Support Systems must include all of the following:

1. A detailed description identifying caregivers and support;

2. The extent of their participation in assisting the recipient with use of the ACD; and

3. Their understanding of the use and their expectations of the ACD.

(g) Current Speech, Language, and Expressive Communication Status must include all of the following:

1. Identification and description of the recipient's expressive or receptive (language comprehension) communication impairment diagnosis;

2. Speech skills and prognosis;

3. Communication behaviors and interaction skills (i.e., styles and patterns);

4. Description of current communication strategies, including use of an ACD, if any; and

5. Previous treatment of communication problems.

(h) Communication Needs Inventory must include all of the following:

1. Description of recipient's current and projected (e.g., within five years) speech/language needs;

2. Communication partners and tasks, including partners' communication abilities and limitations, if any; and

3. Communication environments and constraints which affect ACD selection and/or features.

(i) Summary of Recipient Limitations which must contain a description of the communication limitations.

(j) ACD Assessment Components must contain a justification for and use to be made of each component and accessory requested.

(k) Identification of *at least* two ACDs considered for recipient to include all of the following:

1. Identification of the significant characteristics and features of the ACDs considered for the recipient;

2. Identification of the cost of the ACDs considered for the recipient (including all required components, accessories, peripherals, and supplies, as appropriate);

3. Identification of manufacturer;

4. Justification stating why a device is the least costly, equally effective alternative form of treatment for the recipient; and

5. Medical justification of device preference, if any.

(l) Treatment Plan and Follow-Up must include all of the following:

1. Description of short-term and long-term therapy goals;

2. Assessment criteria to measure the recipient's progress toward achieving short-term and long-term communication goals;

3. Expected outcomes and description of how device will contribute to these outcomes; and

4. Training plan to maximize use of ACD.

(m) Documentation of recipient's trial use of equipment must include all of the following:

1. Amount of time;

2. Location; and

3. Analysis of ability to use equipment.

(n) Documentation of qualifications of speech/language pathologists and other professionals submitting portions of the evaluation must be present. Physicians are exempt from this requirement.

(o) A signed statement by submitting professionals that they have no financial or other affiliation with manufacturer, vendor, or sales representative of ACDs must be present. One statement signed by all professionals will suffice.

(p) Medicaid reserves the right to request additional information and/or evaluations by appropriate professionals.

(8) ACDs are subject to the following limitations. ACDs, including components and accessories, will be modified or replaced only under the following circumstances:

(a) Medical Change: Upon the request of recipient if a significant medical change occurs in the recipient's condition which significantly alters the effectiveness of the device.

(b) Age of Equipment: ACDs outside the manufacturer's or other applicable warranty which do not operate to capacity will be repaired. At such time as repair is no longer cost-effective, upon request by the recipient, replacement of identical or comparable component or components will be made. Full documentation of the history of the service, maintenance, and repair of the device must accompany such requests.

(c) Technological Advances: No replacements or modifications will be approved based on technological advances unless the new technology would meet a significant medical need of the recipient which is currently unmet by the present device.

(d) All requests for replacement or modification as outlined in A-C above will require a new evaluation and complete documentation. If new equipment is approved, the old equipment must be turned in.

(e) Invoice: The manufacturer's invoice must be forwarded to the Medicaid Prior Authorization unit at the time the claim is filed.

(f) Trial Period: No communication components will be approved unless the client has used the equipment and demonstrated an ability to use the equipment. Prior authorization for rental may be obtained for a trial period. This demonstrated ability can be documented through periodic use of sample/demonstration equipment. Adequate supporting documentation must accompany the request.

(g) Repair: Repairs are covered only to the extent not covered by the manufacturer's warranty. Repairs must be prior authorized. Battery replacement is not considered repair and does not require prior authorization.

(h) Loss/Damage: Replacement of identical components due to loss or damage must be prior authorized. These requests will be considered only if the loss or damage is not the result of misuse, neglect, or malicious acts by the users.

(i) Component/Accessory Limits: Components or accessories which are not medically required will not be approved. Examples of non-covered items include, but are not limited to, printers, modems, service contracts, office/business software, software intended for academic purposes, workstations, or any accessory that is not medically required.

Author: Patricia Harris, Administrator, LTC Project Development/Policy Unit.
Statutory Authority: State Plan; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: April 26, 1999. Amended: Filed August 21, 2001; effective November 16, 2001.

Rule No: 560-X-13-.15 Oxygen Therapy Coverage

(1) Effective December 1, 2000, Oxygen Therapy is covered for adults based on medical necessity and must be prior authorized by the Medicaid Agency. Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form. The request must be accompanied by appropriate medical and other required documentation.

(2) The medical diagnosis must indicate a chronic debilitating medical condition, with evidence that other forms of treatment (such as medical and physical therapy directed at secretions, bronchospasm and infection) were tried without success and that continuous oxygen therapy is required. Oxygen will not be approved for PRN use only.

Author: Patricia Harris, Administrator, LTC Project Development/Policy Unit.
Statutory Authority: State Plan; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: New Rule: Filed August 21, 2001; effective November 16, 2001.

Rule No. 560-X-13-.16 External Breast Prostheses

(1) Effective June 1, 2001, external breast prostheses following mastectomy for breast cancer are covered for all Medicaid-eligible recipients meeting the criteria.

(2) Coverage is available for the external breast prostheses when all of the following criteria are met:

(a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses;

(b) The date of the mastectomy and the ICD-9 diagnosis code for which was performed (174.0-174.9, 198.81, 233.0) is provided in the clinical statement section of the appropriate Alabama Prior Review and Authorization Request Form; and

(c) The appropriate procedure codes are billed as indicated below:

Procedure Code	Description	Limits
L8000	Breast prosthesis, mastectomy bra, maximum of 4 on initial request.	6/year
L8015	External breast prosthesis garment, with mastectomy form	2/year
L8020	Breast prosthesis, mastectomy form	**
L8030	Breast prosthesis, silicone or equal	**
*L8035	Custom breast prosthesis, post mastectomy, molded to patient model	
*L8039	Breast prosthesis, not otherwise classified evaluated on a case-by-case basis with submission of pricing information and medical documentation	

*These codes will be reviewed on a case-by-case basis. Additional documentation may be requested to determine medical necessity for coverage.

**Limited to two of L8020 per year or one L8020 and one L8030 per year or two of L8030 per year or one L8030 and one L8020 per year.

(2) Requests for prior authorization must be made on the appropriate Alabama Prior Review and Authorization Request Form and submitted to the EDS Prior Authorization Unit to obtain approval before providing the prosthetic devices.

(3) Maximum calendar year limits apply to each of the procedures as indicated above.

Author: Patricia Harris, Administrator, LTC Program Management Unit.
Statutory Authority: State Plan; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: New Rule: Filed August 21, 2001; effective November 16, 2001. **Amended:** Filed June 21, 2004; effective September 15, 2004.

Rule No. 560-X-13-.17 Motorized/Power Wheelchairs for Adults

(1) Motorized/power wheelchairs are a covered benefit for patients aged 21 and over who meet full Medicaid eligibility criteria and medical necessity. Motorized/power wheelchair base codes covered are K0010, K0011, K0012, K0014. The patient must meet criteria applicable to manual wheelchairs pursuant to this chapter and the Medicaid Provider Manual and the following additional criteria:

(a) Documentation that a manual wheelchair cannot meet medical needs; and

(b) Documentation of long term need for the chair (6 months or longer).

(2) Application process: All requests for motorized/power wheelchairs are subject to the Medicaid Prior Approval provisions and the following additional provisions:

(a) Medical documentation to support diagnosis from the patient's attending physician who has conducted a medical evaluation consisting of medical history, physical examination, assessment, and plan of care.

(b) An evaluation by a Physical Therapist or Occupational Therapist who meets credentialing requirements as provided in the Motorized/Power Wheelchair section of the Medicaid Provider Manual, conducted at sites specified therein and in accordance with, and the completion of, a form approved and provided by Medicaid.

(c) A supplier providing motorized/power wheelchairs to recipients must be registered as a Rehabilitation Technology Supplier (RTS) by the National Registry of Rehabilitation Technology Suppliers (NRRTS). As an alternative, a supplier shall be certified as a Certified Rehabilitation Technology Supplier (CRTS) or Assistive Technology Supplier (ATS) from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). After October 1, 2004, only suppliers who are certified may participate.

(d) Itemized list of items with pricing.

(3) Reimbursement will be made pursuant to Rule 560-X-13-.10.

(4) Limitations and Exclusions

(a) Patients may be approved for one motorized/power wheelchair every five years based on medical necessity/criteria.

(b) Home/environmental and vehicle adaptations, equipment and modifications are not covered.

(c) Repairs and/or replacement of parts require Prior Authorization.

Author: Wanda J. Davis, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: New Rule: Emergency Rule filed and effective June 20, 2003. Amended: Filed July 21, 2003; effective October 24, 2003. Amended: Filed June 21, 2004; effective September 15, 2004. **Amended:** Filed July 20, 2005; effective October 14, 2005.

Rule No. 560-X-13-.18 Basic Level Prosthetics, Orthotics, and Pedorthics for Adults. New Rule

(1) Basic level prosthetics, orthotics and pedorthics are covered benefits to Medicaid eligibles between the ages of 21 and 65 in a noninstitutional setting. These

covered benefits are provided only by prior authorization from the Alabama Medicaid Agency and based on medical necessity. The patient must meet established Medicaid criteria applicable to prosthetic, orthotic, and pedorthic devices pursuant to this chapter and the Medicaid Provider Manual.

Author: Hattie Nettles, Associate Director, LTC Policy Advisory Unit.
Statutory Authority: State Plan Attachments 3.1-A and 4.19-B; 42 CFR, Section 440.70; Title XIX, Social Security Act.
History: New Rule: Filed December 17, 2007; effective March 17, 2008.